



The U.S. Supreme Court’s Ruling on Federal Health Care Reform: What it Means for Georgia Going Forward

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On June 28th, after months of anticipation, the United States Supreme Court issued its opinion on the constitutionality of the Patient Protection and Affordable Care Act (commonly called the Affordable Care Act or ACA). In the case of National Federation of Independent Businesses v. Sebelius, a narrowly divided Court upheld the constitutionality of the law, with one major exception.

From the moment it was signed into law, the most controversial provision of ACA has been the law’s requirement that most individuals have health insurance or pay a financial penalty, known as the individual mandate. Debate over the constitutionality of the individual mandate had centered on whether or not this provision was a valid exercise of congressional power under the Commerce Clause (Art. I, § 8, cl. 3). In an opinion authored by Chief Justice John Roberts, the Court found that the individual mandate could not be found to be constitutional by relying on the Commerce Clause alone, as not having health insurance constitutes inactivity rather than existing commercial activity. However, in a largely unexpected twist, the Court, by a 5 to 4 vote, ultimately upheld the constitutionality of the individual mandate on the basis that the financial penalty for not having health insurance could be construed to be a tax and thus is a valid exercise of Congress’s Taxing Power under Art. I, § 8, cl. 1 of the Constitution.

In another somewhat unanticipated development, the Court struck down the penalty to states who fail to expand their Medicaid programs. ACA requires all states to expand their Medicaid programs to cover all individuals under the age of 65 with incomes up to 133 percent of the federal poverty level (FPL) or risk losing all their existing funding. However, by a 7 to 2 vote, the Court found that the penalty of withdrawing all Medicaid funding was unconstitutionally coercive. The Supreme Court’s ruling effectively treats the expansion under ACA as a new and separate program from the existing Medicaid program, and states may choose whether or not to participate in the new Medicaid expansion program.

Going forward with an Exchange

With the constitutionality of ACA settled by the Supreme Court, Georgia must now make several decisions about what steps to take towards implementation of its provisions. In particular, Georgia’s leaders must determine what actions it will take regarding the establishment of a health insurance exchange. ACA requires health insurance exchanges to be operated in all 50 states beginning in 2014. Intended to make the purchase of insurance more affordable and accessible, the exchanges will be online marketplaces in which individuals and small businesses will be able to compare and purchase health insurance policies. ACA creates two types of state-based exchanges, which can be run separately or merged as one exchange. The American Health Benefit Exchange will allow U.S. citizens and legal immigrants who do not receive employer-based insurance or who do not qualify for public assistance to purchase an individual policy. Another exchange, known as the Small Business

Health Options Program or SHOP, will allow small businesses with up to 100 employees to purchase coverage.

Georgia has the option of doing nothing at all towards the establishment of an exchange. If that is the case, the federal government will operate an exchange in our state in 2014. If Georgia decides to run its own exchange from the outset, however, the state must take action towards its establishment fairly soon. Under federal regulations, states must be approved or conditionally approved by the U.S. Department of Health and Human Services (HHS) to operate a state-based exchange beginning in 2014. Recently, HHS announced that states are expected to submit an exchange blueprint by November 16, 2012 in order to prevent the federal government from establishing an exchange in the state effective January 2014. States that choose to have the federal government operate their exchanges also have the option to pursue a state partnership exchange, in which the federal government operates the exchange but states administer certain activities related to plan management or consumer assistance; such states must also meet the November 16th deadline for providing exchange plans to HHS.

Approval for a state-run exchange will be granted by HHS once the state has demonstrated the ability to satisfactorily perform all required exchange activities. If a state does not meet all exchange approval requirements, the state may still receive conditional approval if the state can show significant progress toward these requirements and that it will be operationally ready for the initial enrollment period beginning October 1, 2013. Although Georgia has not enacted legislation to establish an exchange, the state may still be able to receive conditional approval for exchange plans. However, the General Assembly must still pass enabling legislation before a state-run exchange can be fully implemented. This means that in order for Georgia to run its own exchange in 2014, such legislation must be passed in 2013.

It is possible for a state to begin running its own exchange after 2014. However, federal regulations still require the state to receive approval by the federal government a year in advance of the proposed implementation of the exchange, and the state must submit a blue print for an exchange at least 30 business days in advance of the required approval date.

Assuming Georgia chooses to move forward with setting up an exchange, state leaders must make several key decisions about its design. Such decisions include deciding what entity will oversee the administration of the exchange and deciding whether to establish a regional or interstate exchange (an option under ACA). Georgia would also have to decide whether to operate separate exchanges for individuals and businesses or whether to combine them into a single exchange; if we choose the latter, we must also determine whether to have separate or combined risk pools for the individual and small business markets. Other issues that must be dealt with include, but are not limited to, the essential health benefits package for plans sold in the exchange, establishing a technology system that can direct eligible exchange applicants to Medicaid and PeachCare for enrollment (as required by ACA), and determining whether to allow the exchange to selectively contract with health insurance plans or whether to accept all plans that seek to do business within the exchange.

Medicaid Expansion Decision- Unanswered Questions

In the aftermath of the Supreme Court decision, Georgia now may decide whether or not to participate in the expansion of Medicaid eligibility. In doing so, Georgia's leaders must weigh the potential benefits of providing health care coverage for Georgians who are now uninsured against the still uncertain costs of expanding the already heavily burdened Georgia Medicaid program. According to an analysis by the Urban Institute, 51.9 percent of uninsured Georgians, approximately 974,000, will be eligible for Medicaid under the ACA expansion. How many of these Georgians would actually enroll in Medicaid is unclear. According to its most recently released estimates, the Department of

Community Health (DCH) projects that the expansion of Medicaid eligibility will add over 620,000 individuals in 2014, with a total of nearly 700,000 new enrollees by 2023.

Under ACA, states receive a greatly enhanced federal match for the costs of individuals who are newly eligible for Medicaid under ACA. From 2014 through 2016, the federal government will provide 100 percent funding for such newly eligibles; after that point the federal match will gradually decline to 90 percent for 2020 and subsequent years. Even with this enhanced federal match, DCH estimates that the Medicaid expansion will result in over \$4.5 billion in additional state spending by 2023. Moreover, this possible expansion comes at a time when Georgia's Medicaid program is already experiencing significant financial challenges. DCH recently announced that the Medicaid program faces a deficit of nearly \$308.2 million in Fiscal Year 2013; in addition, the Medicaid program had a \$90.5 million deficit in Fiscal Year 2013.

While the costs of extending Medicaid eligibility pose a significant disincentive to expanding Medicaid, Georgia's leaders may also be reluctant to pass on an opportunity to provide health coverage to thousands of Georgians who currently lack health insurance. According to Census Bureau statistics, approximately 20 percent of Georgians are uninsured, with over 1.9 million Georgians lacking coverage. Hospitals and other health care providers are likely to strongly advocate expanding Medicaid so as to increase the number of patients with coverage and reduce the costs of uncompensated care. According to the Georgia Hospital Association (GHA), in 2011 Georgia hospitals treated over a million uninsured patients, accounting for 15.94 percent of hospital patients. The treatment of such patients costs the state's hospitals more than \$1.5 billion annually, according to GHA. Hospitals that treat large numbers of indigent patients are eligible for payments from state Medicaid programs known as disproportionate share (DSH) payments, but ACA includes cuts to DSH programs; when ACA was passed, many hospitals viewed the DSH cuts as a tradeoff for having more insured patients.

Complicating Georgia's decision over whether or not to expand Medicaid is the fact that low income adults who would have qualified for Medicaid may not be eligible for another benefit provided by ACA. The law provides for persons with incomes between 133 to 400 percent of the FPL to be eligible for premium subsidies to help them purchase health insurance through an exchange. However, persons with incomes below this threshold do not qualify for the subsidies under ACA, presumably because they were supposed to be covered by Medicaid.

As Georgia and other states consider how to proceed with the now optional Medicaid expansion, questions remain about the ramifications of the Supreme Court's decision. In a letter to the Republican Governors Association on July 13th, the acting administrator for the Centers for Medicare and Medicaid Services (CMS) stated that there is no deadline for a state to inform CMS of its expansion plans and that additional guidance will be issued over the next year and a half. Other questions about state options include whether it would be possible for a state to partially expand eligibility or whether a state could expand eligibility after 2014. Moreover, ACA requires states to maintain their current levels of income eligibility for adults in Medicaid until 2014 and for children in Medicaid and in the Children's Health Insurance Program (CHIP) until 2019. Under the law, the penalty for not meeting this requirement (known as a Maintenance of Effort or MOE requirement) is the loss of current Medicaid funding, the same penalty that the Supreme Court just found to be unconstitutional. Since the Supreme Court's decision does not directly address MOE requirements, these provisions appear to stand for now. However, the MOE requirements will likely be a source of uncertainty and controversy as states look for ways to control their Medicaid budgets.